National Institute for Health and Care Excellence

# Osteoporosis

**Stakeholder engagement – deadline for comments** 17:00 on 29/07/2025

**email**:[QualityStandards@nice.org.uk](mailto:QualityStandards@nice.org.uk)

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly or arrive after the deadline.

# Introduction

This quality standard covers managing osteoporosis in adults (aged 18 and over), including assessing risk and preventing fragility fractures. It will replace the existing [NICE quality standard for osteoporosis (QS149)](https://www.nice.org.uk/guidance/qs149). The topic was identified for update because source guidance is in development [Osteoporosis: risk assessment, treatment, and fragility fracture prevention (update)](https://www.nice.org.uk/guidance/indevelopment/gid-ng10216).

The key potential development sources for this quality standard is [Osteoporosis: assessing the risk of fragility fracture. NICE guideline CG146](https://www.nice.org.uk/guidance/cg146) (2012, updated 2017) and its update.

Use the form to tell us:

* **What are the** **key areas for quality improvement** that you would want to see covered by this quality standard? **Please prioritise up to 5 areas** which you consider as having the greatest potential to improve the quality of care. Please state the specific aspects of care or service delivery that should be addressed, including the actions that you feel would most improve quality. Note that all actions or interventions to improve quality within the quality standard must be based on recommendations from a NICE or high-quality external guidance. Please see the [final scope](https://www.nice.org.uk/guidance/indevelopment/gid-ng10216/documents) for the guideline update for information on what that may cover.

# Organisation details

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| --- | --- |
| **Organisation name – Stakeholder or respondent**  (if you are responding as an individual rather than a registered stakeholder please leave blank) | Royal College of General Practitioners |
| **Disclosure**  Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry. | None |
| **Name of person completing form** | Michael Mulholland/ Adrian Hayter |
| **Supporting the quality standard**  Would your organisation like to express an interest in formally supporting this quality standard? [More information.](https://www.nice.org.uk/standards-and-indicators/get-involved/support-a-quality-standard) | No |

# Quality improvement comments

Type directly into this table. Don’t paste other tables into this table as your comments could get lost.

|  |  |  |  |
| --- | --- | --- | --- |
| **Key area for quality improvement** | **Why is this a key area for quality improvement?** | **Data sources** | **Supporting information** |
| Separately list each of the 5 key areas for quality improvement that you would want to see covered by this quality standard | Evidence of information that care in the suggested key areas for quality improvement is poor or variable and requires improvement. Please include any evidence of inequalities and health inequalities in the suggested key areas for quality improvement. | As the quality statements must be measurable, please include any information on available data sources.  Information can include:   * National data sources that collect data relating to your suggested key areas for quality improvement * National audits * Other data sources | Information can include sections or recommendations in a NICE / high-quality external guidance relating to the key areas for quality improvement |
| **Example:**  Older adults presenting to emergency care acutely unwell should be rapidly and comprehensively assessed for the presence of serious underlying infections by clinicians with expertise in assessment of acute frailty | **Example:** Older adults with frailty often do not present with typical symptoms of bacterial meningitis or sepsis which are easily missed or mistaken for other problems leading to missed diagnosis and delayed treatment with poor outcomes including long lengths of hospital stay.  GIRFT identified variation in frailty identification and assessment with many older patients who arrive through the emergency pathway not having an initial assessment. Where patients are not assessed, it’s less likely there will be an effective early response because patients may be assessed by staff in A&E or other medical or surgical specialties where frailty assessment is not embedded in pathways and practice. | **Example:** NHS England CQUIN05 specifies rapid identification of frailty in emergency care settings followed by initiation of comprehensive geriatric assessment. | **Example:** There is considerable variability in clinical findings among older adults presenting with bacterial meningitis. Febrile responses are often blunted or absent and pyrexia is not a universal finding varying between 59% and 100% in published studies. Similarly, headache and neck stiffness have been noted in only 50% of older adults with meningitis and may be misinterpreted due to co-morbidity such as cervical spondyloarthropathy.  https://academic.oup.com/cid/article/33/8/1380/347483 |
| Key area for quality improvement 1  Early diagnosis in Primary Care through targeted identification of those who might be at risk of developing osteoporosis considering a health equity approach. | Early diagnosis through targeted population health data and intelligence which identifies those who are most likely to be at risk and tackling health inequalities and outcomes.  It is recognised that this is an area of disparity and with data available at a local level it is important that measures are developed for each population to identify those most at risk at an early stage of the condition  An example would be screening and diagnosis in people with a learning disability, although there would be many other population groups to be considered also.  Access to Diagnostic services ie DEXA scanning (variation across the country) | * [Disparities in Osteoporosis Prevention and Care: Understanding Gender, Racial, and Ethnic Dynamics - PubMed](https://pubmed.ncbi.nlm.nih.gov/38916641/) * [Ageing, osteoporosis and intellectual disability; risks differ, and diagnosis can be missed - Burke - 2024 - British Journal of Learning Disabilities - Wiley Online Library](https://onlinelibrary.wiley.com/doi/full/10.1111/bld.12598?msockid=0fc084d33d556132363b92f03c7260d3) | RCGP Health Equity hub  [Health equity special interest group](https://www.rcgp.org.uk/about/communities-groups/health-inequalities)  People with a learning disability are younger when they receive a diagnosis of osteoporosis than the general population and are less likely to have their risk assessed. |
| Key area for quality improvement 2  Falls and Fracture Prevention a whole system approach | Prevention  Fracture risks and prevention of serious injury and mortality involves a whole system integrated approach. Reducing Fractures involves not only the comprehensive roll out of Fracture Liaison Services but a comprehensive service which integrates with other programmes of work across health and social care. Wider use of Fracture risk prevention tools in primary care. | <https://doi.org/10.1093/ageing/afac205> (World guidelines for falls prevention and management for older adults)  [Osteoporosis prevention and osteoporosis exercise in community-based public health programs - PMC](https://pmc.ncbi.nlm.nih.gov/articles/PMC6372810/) | ‘Preventive Medicine’ is an RCGP Clinical Priority and for Osteoporosis there are two Preventive Medicine ssues  Prevention of Osteoporosis and Falls and Fragility Fracture prevention  In the prevention of osteoporosis there is a wider social ecologic model.  For Falls and Fragility fracture prevention there is a targeted approach. |
| Key area for quality improvement 3  Shared Decision making in considering treatment options | Medication  <https://onlinelibrary.wiley.com/doi/full/10.1002/hsr2.849>  <https://www.nice.org.uk/guidance/ta464/resources/bisphosphonates-for-treating-osteoporosis-patient-decision-aid-pdf-6896787085> (Patient decision aids) | The results of this study in 2022 highlight that patient preferences should be considered by physicians since they can impact adherence to the treatment and its efficacy. Currently, available PDAs can help to engage patients through shared decision-making. Since the purpose of a PDA is to help patients in the decision-making process there is certain information that must necessarily be included in the PDA. The information gathered in this review regarding the decision drivers may help to define which content should be included in a PDA.  NICE have supported PDA for Osteoporosis and Bisphosphonate treatment | More widespread use of patient decision aids (accessible for a range of individuals including those living with a learning disability)  More resources to support patients with a range of treatment options.  Consider personalised care including non-drug treatments including exercise and diet |
| Key area for quality improvement 4  Accessible Information to guide patients and their carers | Information  This needs to be accessible information and targeted at high-risk groups | As above use of shared decision making and patient decision aids |  |
| Key area for quality improvement 5  Public Health and wider system support | Support for prevention agenda campaign materials to promote osteoporosis prevention a life course approach from childhood to older age through diet and exercise advice and support especially for those in area of deprivation. |  |  |

# Checklist for submitting comments

* Use this form and submit it as a Word document (not a PDF).
* Complete the disclosure about links with, or funding from, the tobacco industry.
* Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
* Do not paste other tables into this table – type directly into the table.
* **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
* Do not include medical information about yourself or another person from which you or the person could be identified.
* Spell out any abbreviations you use
* Please provide concise supporting information for each key area. Provide reference to examples from the published or grey literature such as national, regional or local reports of variation in care, audits, surveys, confidential enquiries, uptake reports and evaluations such as impact of NICE guidance recommendations
* For copyright reasons, do not include attachments of **published** material such as research articles, letters or leaflets. However, if you give us the full citation, we will obtain our own copy
* Attachments of unpublished reports, local reports / documents are permissible. If you wish to provide academic in confidence material i.e. written but not yet published, or commercial in confidence i.e. internal documentation, highlight this using the highlighter function in Word.

Please return to [QualityStandards@nice.org.uk](mailto:QualityStandards@nice.org.uk)

NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of NICE, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Comments received from registered stakeholders and respondents during our stakeholder engagements are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.